SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0759

CERTIFICATE OF ELECTION FOR REDUCED WIDOW(ER)'S BENEFITS

(Do not write in this space)

1. PRINT NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON *(Hereafter called "Worker")*	ENTER HIS OR HER SOCIAL SECURITY NUMBER — — — — — — — — —
2. PRINT YOUR FULL NAME (*First name, middle initial, last name*)	ENTER YOUR SOCIAL SECURITY NUMBER (*If "none" or "unknown" so indicate.*) — — — — — — — — —

INFORMATION ABOUT REDUCED WIDOW(ER)'S BENEFITS

The law requires that you complete and return this certificate of election if you are at least age 62 and before you reach full retirement age (FRA) and wish to receive reduced widow(er)'s benefits or surviving divorced spouse's benefits. If the deceased worker was receiving reduced benefits, the month of death of the worker is usually your best election choice. However, your election in item 3 below will be reviewed to determine if the month you select is the most advantageous month. If not, we will contact you.

The following will affect the amount of your benefit:

- The month and year you elect to begin to receive benefits will determine the amount of your monthly payments which will continue at a reduced rate even after you reach FRA.
- The rate of the reduction varies depending on your date of birth. It ranges from 19/56 to 10/40 of 1 percent times the number of months from the start of the reduced benefits until the month you reach FRA.
- If the deceased worker was receiving reduced benefits on this Social Security number, your benefit will be further reduced to the larger of the amount of the deceased worker's benefit amount or 82 1/2 percent of the deceased worker's unreduced benefit.
- If another beneficiary is entitled to a monthly survivor benefit on this Social Security number, your benefit may be reduced by the maximum family benefit payable in the month.

3. I elect to accept reduced benefits as provided in Section 202(q) → of the Social Security Act, beginning with Enter any month beginning with the month of the deceased worker's death up to, but not including the month you reach FRA provided that the month you choose is within the past 12 months.	MONTH	YEAR

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature *(First name, middle initial, last name) (Write in ink)* **SIGN HERE** ▶	Date *(Month, day, year)* Telephone Number (include area code)

Mailing Address *(Number and street, Apt. No., P.O. Box, or Rural Route)*

City and State	ZIP Code	Enter Name of County (if any) in which you now live

Witnesses are required ONLY if this certificate has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person completing this certificate must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

Paperwork/Privacy Act Notice:

The information requested on this form is authorized under Sections 202(e), (f) and (q)(3) of the Social Security Act (42 U.S.C. 402(e), (f), and (q)(**3**)**)**. The information requested on the form will be used to determine whether you may be eligible to receive reduced benefits as a widow(er) or a surviving divorced spouse. Your response to these questions is voluntary; however, the Social Security Administration (SSA) cannot review the decision and make a determination about eligibility for payment of reduced benefits on this claim unless the information is furnished. While the information you furnish on this form would almost never be used for any purpose other than the intended use of this form, such information may be disclosed by SSA as generally permitted under U.S.C.§ 552a of the Privacy Act of 1974, as amended. This includes using the information as necessary for administrative purposes or as authorized by routine uses in the Privacy Act system of records. For example, SSA may disclose information to other agencies such as the General Services Administration or the National Archives and Records Administration to comply with Federal Laws requiring the release of information from our records.

SSA may also use the information you give us when we match records by computer. Matched programs compare SSA records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows SSA to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or provided to other agencies are available upon request from any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C . §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Only comments relating to our time estimate should be provided, not the completed form.***